

Quality Strategy



**Medi-Cal Managed Care Division
California Department of Health Services**

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Background: The Medicaid Managed Care Final Rules published June 14, 2002, pursuant to the Balanced Budget Act of 1997, require state Medicaid agencies to create a “Quality Strategy”. (Appendix A) The purpose of the Medi-Cal Managed Care (MCMC) Quality Strategy is to define a strategic framework for health care quality improvement for the agency and its contracted managed care plans. The strategy is built on the California Department of Health Services mission statement, guided by the vision statement of the Medi-Cal Managed Care Division (MMCD).

Mission: *The mission of the California Department of Health Services is to protect and improve the health of all Californians.*

Vision: *All Medi-Cal managed care enrollees will have access to health care which is safe, effective, patient-centered, timely, efficient, and equitable, and which serves to reduce the burden of illness and improve the health and functioning of the enrolled individuals and population.*

Development: The MMCD Quality Strategy has been developed through an iterative process involving input from contracted managed care plans, staff, and advocacy organizations. Drafts of the Quality Strategy were provided to members of the MMCD Advisory Group, the MMCD Medical Directors Work Group, and the MMCD Quality Improvement Work Group. The Advisory Group includes representatives of Plans and consumer advocacy organizations. MMCD considered written comments and held several discussions with each of these groups. A matrix including all comments and suggestions was also distributed for review and further input prior to adoption of the final Quality Strategy.

Overview: The core goals of MMCD’s Quality Strategy are to:

- increase accountability for the quality of care;
- improve the quality of care;
- reduce health care disparities; and
- continually improve MMCD’s performance.

The remainder of this document presents MMCD’s quality goals and objectives, reviews current quality policies and activities, and identifies priorities for improvement and proposed improvement strategies. The Quality Strategy provides a road map for MMCD as it endeavors to increase plan and system accountability for quality and improve the quality of care. The timeline for implementation of these strategies will, of course, be dependent on the availability of resources. MMCD contracts and partners with an External Quality Review Organization to implement its quality strategy, pursuant to BBA requirements (see Appendix B).

Goal 1 : MMCD will increase and maintain accountability for the quality of care.

Objective 1a: MMCD will ensure that contract language and policies incorporate quality requirements which:

- i. Adequately protect enrollee access to care
- ii. Include requirements for plan structure and operations sufficient for plans to meet all other contractual obligations
- iii. Clearly define the scope of contracted services and contractual obligations with regard to the standard of care
- iv. Define plan responsibilities for coordination of care among plan providers and with other agencies and out-of-network providers
- v. Define plan responsibilities for quality monitoring, measurement, and improvement
- vi. Incorporate quality benchmarks to define minimum quality standards and goals for improvement.

MMCD's existing contracts and policies adequately address quality issues and requirements. Appendix C contains a summary of MMCD current standard contract language and policies relevant to (A1i) through (A1vi.) above; full boilerplate contract language is provided in Appendix D.

MMCD will keep abreast of new developments in medical and health care, to ensure that significant changes in the evidence-based standard of care are reflected in contract language and policies.

Priority areas for improvement and *proposed improvement strategies* for contracts and policies related to quality:

- a. Several contract sections require clarification or expansion:

MMCD will develop policy letters on:

- *Initial Health Assessment*
- *Children with Special Health Care Needs*
- *Dispensing of pharmaceuticals in emergency rooms*
- *Pharmacy authorization request and denial processes*
- *Advance directives.*

b. Care coordination remains difficult: Plans are contractually required to work with other agencies for care coordination, but there are not always reciprocal requirements, and roles of agencies may be confusing, especially with regard to services for children with special needs. Care coordination is especially challenging because of perceived restrictions on information sharing related to confidentiality laws

MMCD will work with other agencies and with the Health and Human Services Agency to develop a written matrix of state agency roles and responsibilities, specifically with respect to care of children with special health care needs. MMCD will seek agreements with other agencies to improve reciprocal care coordination.

MMCD will work with other agencies to clarify state confidentiality laws pertaining to the sharing of information for purposes of care coordination and quality improvement.

c. Current contracts establish minimum quality thresholds (MPLs, or Minimum Performance Levels), but MMCD has not determined a schedule for raising the quality thresholds over time:

MMCD will evaluate whether the current MPLs foster continuous system-wide quality improvement and, if necessary, develop a proposal for raising contractual quality thresholds over time.

Objective 1b .Monitor contracts and ensure plan compliance with access and quality standards

MMCD current monitoring activities include:

- i. Review of Plan documents (e.g. provider network lists and reports, evidence of coverage, policies and procedures, marketing materials, MOUs with other agencies, Plan reports on quality improvement activities);
- ii. Medical audits conducted jointly by the DHS Audits and Investigations unit and the Department of Managed Health Care every three years, with interim follow-up by MMCD on deficiencies and corrective action plans;
- iii. Review of beneficiary complaints and grievances (e.g. call center reports, grievance and complaint logs, ombudsperson calls, state fair hearings);
- iv. Facility site review (FSR) of all primary care provider sites every three years, by certified/trained reviewers using standardized tool and with standardized data submission;
- v. Annual review of each contracted plan by the External Quality Review Organization.

Appendix E contains documents pertaining to current monitoring activities.

Priority areas for improvement and *proposed improvement strategies* for monitoring:

a. Need for increased focus: Current monitoring activities are resource intensive for both Plans and DHS, but inadequately focused to yield information of maximal value for quality accountability and improvement. Some audit activities are redundant of those conducted by accrediting agencies. Monitoring is not data-driven, does not target poor performers or specific areas of concern, and is insufficiently focused on outcomes and quality (as opposed to structure). Multiple MMCD branches are involved in plan monitoring and review, without a defined process for synthesizing and integrating the findings.

MMCD will develop and implement a plan to increase the resource-efficiency of monitoring activities, including:

- *Investigation of the feasibility of “deeming” of audits by other agencies (e.g. NCQA) to reduce the total number of audits for high performing plans, while maintaining adequate oversight;*
- *Mechanisms for improved integration of information from multiple monitoring activities, through Branch chief review of the Dashboard Report, and regular multi-unit review and discussion of data and information about each Plan from all monitoring sources;*
- *Increased use of data from all sources (e.g. audit, complaints, utilization and quality measures, other encounter data analysis) to target audits, and development of criteria for targeting;*
- *Methods to utilize available plan data (e.g. tracking of IHAs) for monitoring; and*
- *Strategies to conduct targeted monitoring in light of resource limitations (e.g. use FSRs with DHS chart over-read)*

b. Stakeholder input: There is no mechanism for discussion about monitoring priorities between MMCD and stakeholders.

MMCD will restructure the MMCD advisory committee to enable more in-depth discussion of monitoring issues, through establishment of a monitoring subcommittee.

c. Clear consequences: Plans that do not meet minimum performance levels are required to implement Quality Improvement projects to improve performance. However, MMCD has not established other clear consequences for plans with persistent poor performance.

MMCD will develop a proposal for “progressive sanctions” for poor performance, in conjunction with DMHC and A&I.

- d. Audit results not available: Advocates are concerned that audit results, deficiencies, and corrective action plans are not made public in a timely manner.

MMCD will work with Audits and Investigations to ensure that audit results are made public more timely.

Goal 1: MMCD will increase and maintain accountability for the quality of care.

1c. MMCD will implement methods to continuously measure the quality of care, in order to identify plan-specific and system-wide quality performance gaps and opportunities for improvement.

Current MMCD quality measurement activities include:

- i. Plans are required to annually provide audited results for the DHS “External Accountability Set”, which includes selected HEDIS measures and several DHS-developed measures. Quality measures for specialty plans (e.g. AIDS HealthCare Foundation, SCAN, Family Mosaic) are modified to reflect plan membership. A list of accountability measures is included in Appendix F.
- ii. Plans must participate bi-annually in the Consumer Assessment of Health Plans Survey (CAHPS), or, for specialty plans, an MMCD-approved enrollee survey.
- iii. Each Quality Improvement Project (see below) incorporates a measurement component, with required baseline and periodic measurement.

Priority areas for improvement and *proposed improvement strategies* for measuring quality of care:

- (a) Need for more assessment of whole population and system quality: The current quality measurement system focuses on measures that allow plan-to-plan comparisons. For methodological reasons, these measures often assess the quality of care only for individuals who meet defined enrollment criteria; individuals who change plans, move from FFS to managed care, or move on and off Medi-Cal are thus excluded.

MMCD will explore methods for evaluating quality for its entire enrolled population and to measure the quality of care in the Medi-Cal managed care system (e.g. by county, without continuous enrollment requirements, across plans, or across FFS/MC).

- (b) Encounter data is under-utilized: Encounter data is currently under-utilized for purposes of quality monitoring and measurement, in part due to uncertainty as to the

completeness of data reporting. Assessing and improving the completeness and reliability of encounter data is thus a prerequisite to expanded use of the data for accountability purposes.

MMCD will develop and implement a strategy for assessing and improving the completeness, reliability, and timeliness of encounter data, including:

- *Convene an encounter data improvement group including data producers and users;*
- *Compare encounter data to “gold standard” data such as hospital discharge data or birth certificate data;*
- *Establish benchmarks and targets for timeliness, accuracy, and completeness of data, with assistance from health services researchers and based on above comparison, data from other states (e.g. NY, WI), and national utilization data (e.g. AHRQ);*
- *Provide increased feedback to plans regarding encounter data (e.g. Medical Director’s reports on administrative utilization of services reports);*
- *Develop incentives for improved encounter data and sanctions for poor encounter data;*
- *Set specific dates for use of encounter data for default enrollment, rate setting, and quality incentives.*

(c) Measurement set limited: While the DHS External Accountability Set covers a cross-section of key quality indicators, it is limited in scope. Many important aspects of care are not assessed; most of the measures evaluate the process of care, rather than the outcomes of care.

MMCD will endeavor to expand the scope of its quality measurement, remaining mindful of the often resource-intensive nature of quality measurement:

- *A plan for measure rotation will be developed;*
- *The expanded use of MIS/DSS data for quality measurement will be explored (e.g. pharmacy data to evaluate over-use of antibiotics, other administrative quality measures);*
- *MMCD will begin to use other available data sets to assess the quality of care in Medi-Cal managed care (e.g. birth-certificate data –adequacy of prenatal care, hospital discharge data- ambulatory care sensitive hospitalizations, CHDP data-prevalence of obesity, cancer registry data-stage of detection);*

- *MMCD will consult with health services researchers to identify feasible measurement strategies to assess health outcomes (e.g. complications of diabetes, school absence from asthma) and to measure additional quality domains (e.g. care coordination, cultural competence, health education, provider satisfaction);*
- *MMCD will explore ways to build on existing chart review (e.g. HEDIS, FSR) for expansion of quality measurement.*

(d) Measures do not assess disparities: MMCD's current accountability measures do not adequately assess disparities in quality of care with respect to race/ethnicity, gender, or language.

MMCD will explore methods for better assessing disparities in quality of care.

(e) CAHPS response rate low: The Medi-Cal managed care response rate on the CAHPS survey has historically been very low, raising questions as to its validity as a sole method for obtaining enrollee assessments of quality of care. One reason for low response rate is the historically poor enrollee contact information in the Medi-Cal Eligibility Data System.

MMCD will work with its contracted External Quality Review Organization to improve the CAHPS response rate.

MMCD will explore alternative tools for evaluating consumer satisfaction and patient assessment of the care experience.

MMCD will work with DSS and HCO/Maximus to improve the validity of contact information in the MEDS file.

(f) CAHPS not county-specific: While MMCD has initiated county-specific reporting of HEDIS measures, CAHPS is performed at a contract level. Thus, consumer assessment measures reflect a single county for Local Initiatives, but multiple counties for commercial plans. Geographic differences in patient satisfaction and experience may thus be masked.

Resource constraints currently preclude conducting of CAHPS at a county level; MMCD remains cognizant of this concern.

(g) Quality measurement data not widely disseminated: MMCD currently provides reports on HEDIS and CAHPS. However, the technical reports are not consumer-friendly, and no report provides an overall view of a Plan's quality of care.

A Consumer Guide to Quality in Medi-Cal Managed Care will be distributed starting in Fall, 2004.

MMCD's External Quality Review Organization will produce an annual quality review for each plan, which integrates information from the External Accountability Set and other sources.

Goal 2 : MMCD will improve the quality of care for Medi-Cal managed care enrollees.

Objective 2a: Develop and implement mechanisms to increase collaboration for quality.

Collaboration among plans, with MMCD, and with stakeholders facilitates quality improvement through sharing of resources and best practices. MMCD requires that contracted plans participate in one small group collaborative and one statewide collaborative.

MMCD will strive to increase plan-plan and plan-MMCD collaboration for quality through:

- *Implementation of Quality Improvement Collaboratives – small group and statewide (e.g. Adolescent Health statewide collaborative; diabetes and immunizations small group collaboratives)*
- *Creation of mechanisms to increase sharing of best practices among plans (e.g. website, listserv, clearinghouse);*
- *Evaluation of various mechanisms for increased technical assistance to plans with poor performance (e.g. “credit” or payment for plan-to-plan TA; use of subject matter experts within DHS or EQRO)*
- *Training for MMCD and Plan staff on the science of quality improvement.*

MMCD will strive to increase stakeholder-plan-MMCD collaboration for quality through:

- *Implementation of a structured process for selection of QI priorities, including discussion in Advisory Committee subcommittees;*
- *Collaboration with other DHS units (e.g. immunizations branch, maternal and child health) and other state agencies (e.g. mental health) on quality improvement projects;*
- *Inclusion of providers and community-based organizations in planning and implementation of quality improvement projects.*

Objective 2b: MMCD will work with plans to initiate quality improvement projects, which specifically seek to implement “the Care Model” at the practice level.

There is increasing evidence that quality improvement requires changes at many levels (foremost of which is at the practice site), and an emerging consensus that the care model developed by Dr. Ed Wagner¹ provides a valuable framework for quality improvement. This model addresses the complexity of modern medicine and our health care delivery system, and the critical importance of decision support, practice re-design, clinical information systems, patient self-management, linkage to community resources, and healthy systems change.

MMCD will work with plans to develop quality improvement programs that incorporate the Care Model and practice-level redesign.

Objective 2c: MMCD will develop and implement financial and non-financial incentives for quality.

Weak incentives for quality: At this time, MMCD offers only limited non-financial incentives for quality, through publication of HEDIS and CAHPS technical reports, and annual recognition awards for quality performance.

MMCD will implement new financial and non-financial incentives for quality:

- *Expanded public dissemination of quality performance results (e.g. Consumer Guide on Quality in Medi-Cal Managed Care, annual report on quality);*
- *Default enrollment based on quality;*
- *Inclusion of quality criteria in contract procurement process.*

MMCD will develop a plan and timeline for the implementation of additional incentives based on defensible target benchmarks, such as:

- *Rewards for good quality (e.g. reduced audits, monetary bonuses);*
- *Progressive sanctions for poor performance (e.g. enrollment freeze if Plan does not meet Minimum Performance Level for more than one year).*

Thresholds for quality performance require further definition: MMCD has established Minimum Performance Levels for HEDIS, but has no policy for driving overall system improvement through re-evaluation of the MPLs over time. There are no MPLs based on CAHPS.

¹ <http://www.improvingchroniccare.org/>

MMCD will develop MPLs for CAHPS (and other measures as they are implemented), and will periodically assess the need to raise MPLs to drive overall quality improvement.

Link performance thresholds (high and low) to incentives for good and poor performance.

Reimbursement methods not aligned for quality: MMCD is currently moving to an actuarially based rate-setting method, the new method does not incorporate financial incentives for quality or health-status based risk adjustment. (Risk adjustment takes into account expected medical needs to minimize disparities in payment if some plans care for sicker patients, reducing incentives for adverse risk selection.)

MMCD will:

- *Assess the feasibility of incorporating financial incentives for quality into the rate structure (e.g. bonuses, quality pool)*
- *Research the use of risk-adjustment in rate setting, to evaluate feasibility and alternative methodologies that align payment and resource use.*

Objective 2d: MMCD will improve monitoring of plan QI projects.

MMCD requires plans to conduct four Quality Improvement projects. In the past, some QI projects have not resulted in significant performance improvements, even after many years.

MMCD is currently re-structuring its monitoring of plan QI activities to:

- *Clarify requirements for initial QI project proposals and annual QI project reports;*
- *Conduct more structured on-going review of QI projects by the External Quality Review Organization;*
- *Establish a mechanism for more comprehensive assessment of plan QI programs through telephonic review by MMCD staff.*

Objective 2e: MMCD will work to develop a partnership with stakeholders to improve the quality of care.

- a) Stakeholders and beneficiaries want more information about quality: Currently, distribution of information about quality in Medi-Cal managed care is relatively limited. Enhanced knowledge about quality on the part of enrollees, potential enrollees, and other stakeholders (e.g. advocates, providers, policy-makers) would increase plan accountability and build a constituency for quality improvement.

MMCD will:

- *Distribute the Consumer Guide on Quality of Care in Medi-Cal managed care;*
- *Develop and distribute an annual report on each plan's quality of care;*
- *Expand its annual conference on quality to invite broader stakeholder participation;*
- *Implement the recommendations of the enrollment survey task force related to improving beneficiary choice of plans, as resources allow.*

b) Limited opportunities for stakeholder dialogue: There are currently several forums for dialogue between stakeholders and MMCD about quality of care issues, including the MMCD Advisory Committee, Medical Director's meetings, Quality Improvement Work Group, Health Education Work Group, and plan Community Advisory Councils. However, opportunities for in-depth discussions on quality are limited. Providers are not represented in any of these forums. Lay participants may feel disadvantaged by the technical nature of some discussions about quality.

MMCD will work to improve dialogue about quality and quality improvement with and among all stakeholders, including:

- *Re-structure of the MMCD Advisory Committee to facilitate more in-depth discussions through creation of committees (e.g. quality, marketing, monitoring, incentives);*
- *Inclusion of provider representatives on the Advisory Committee.*

Goal 3 : MMCD will develop and implement programs to reduce health disparities

Objective 3a: Reduce health disparities

Disparities in quality of care persist: Disparities in the quality of health care have been demonstrated, including racial/ethnic disparities, gender disparities, and socio-economic disparities. MMCD collects self-reported data on race/ethnicity at the time of enrollment, for inclusion in the MIS/DSS data system. But there is currently little data on disparities in care in Medi-Cal Managed Care.

MMCD will seek expert consultation to identify and implement methods to measure disparities in quality of care, using available data (administrative, HEDIS, CAHPS). Based on measurement, MMCD will implement quality improvement projects that specifically address disparities.

Goal 4: MMCD will strive to continually improve performance in order to fulfill its commitment to improving the quality of care for Medi-Cal Managed Care enrollees

Objective 4a: MMCD will increase staff expertise on the monitoring, measurement, and improvement of quality in health care.

MMCD will develop and implement a plan for improving staff orientation and training, with specific training on quality of care and the science of quality improvement.

Objective 4b: Quality Strategy: MMCD will implement a process for periodic review and revision of its Quality Strategy, including a method for stakeholder input.

MMCD will conduct a bi-annual review of the Quality Strategy that will include an evaluation of the continued relevance and appropriateness of the defined goals and objectives, an analysis of progress in implementation, and revision as needed. The review will also incorporate identification of priorities for the upcoming years, and definition of relevant benchmarks. The annual review will be conducted in collaboration with the Quality Improvement Work Group and MMCD Advisory Committee to ensure stakeholder input.

Appendix A
External Quality Review Organization: Scope of Work

Appendix B

Final Medicaid Managed Care Rules

§438.204 Elements of State quality strategies

At a minimum, State strategies must include the following:

- (a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.
- (b) Procedures that--
 - (1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.
 - (2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
 - (3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.
- (c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.
- (d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.
- (e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
- (f) An information system that supports initial and ongoing operation and review of the State's quality strategy.
- (g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

Appendix C

Summary of Current Contract and Policy Requirements

Access to Care

MMCD's access to care standards were developed with consideration of beneficiary demographics, traditional patterns of care, and State regulatory requirements. The standards address network capacity, access to primary care and specialist physicians, 24/7 availability of care, safety net providers, and cultural/linguistic competency. They include the following requirements:

- Network capacity: Plans shall maintain a provider network adequate to serve sixty percent (60%) of all eligible. Plans will increase the capacity of the network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first twelve months of operation, if enrollments do not achieve seventy-five (75%) of the required network capacity, the plan's total network capacity requirement may be renegotiated.
- Plans shall maintain an adequate number of inpatient facilities, service sites, professional, allied, specialist and supportive paramedical personnel within their network to provide Covered Services to its Members.
- Plans shall have as a minimum a designated emergency service facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.
- Plans shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22, CCR, Section 53853(a).
- Plans shall meet federal requirements for access to FQHC services, including those in 42 United States Code Section 1396 b (m) and Medicaid Regional Memorandum 93-13. Plan shall reimburse FQHCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 6. If FQHC services are not available in the provider network of either the Local Initiative (LI) Health Plan in the county or Contractor, plan shall reimburse FQHCs for services provided out-of-plan to plan's members at the FQHC rate determined by DHS.
- Plans shall maintain a network of primary care physicians which are located within thirty (30) minutes or ten (10) miles of a member's residence unless the Contractor has a DHS approved alternative time and distance standard.
- Plans shall have a plan physician available 24 hours per day, seven days per week to coordinate the transfer of care of a member whose emergency

condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel.

- Plans shall ensure that the composition of plan's provider network meets the ethnic, cultural, and linguistic needs of plan's members on a continuous basis. Plan shall ensure that any contract terminations do not adversely impact the ethnic composition of the provider network.
- Plans may enter into subcontracts with other entities in order to fulfill the obligations of the contract.
- Plans shall maintain the percentage of Traditional and Safety-Net Provider within a Service Area submitted and approved by DHS. Federally Qualified Health Centers meet the definitions of both Traditional and Safety-Net providers.
- Plans must ensure that a member needing urgent care is seen within 48 hours.
- Plans must ensure that the first prenatal visit for a pregnant member will be available within two weeks.
- Plans must ensure that all members are provided a comprehensive initial health assessment within 120 days of member's date of enrollment.

Structure and Operations

Plan contracts address numerous structural and operational requirements that relate to assuring and improving the quality of care for enrollees. These include:

- Licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 as amended.
- Annual disclosure of potential financial conflicts pursuant to Title 28, CCR, Section 1300.67.3 and Title 22, CCR, Section 53800, 53851 and 53857
- An accountable governing body and necessary resources for full performance as required by the contract
- Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business
- Written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective control

- Plans shall ensure that fiscal and administrative management does not unduly influence medical decisions, including those by sub-contractors and rendering providers.
- Plans shall maintain the organizational and administrative capabilities to carry out its duties and responsibilities under the Contract. This will include at a minimum the following:
 - Designated persons, qualified by training or experience, must be responsible for the Medical Record service.
 - Plan shall maintain a Member and Enrollment reporting system, Management Information System, Member Services, and a Member Grievance System.
 - Financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received.
 - Plans must develop, implement and maintain a utilization management (UM) program which includes the list of services that require prior authorization, persons responsible for UM and their qualifications and their qualifications, procedures to evaluate medical necessity, including use of appropriate clinical standards or guidelines and criteria used for service authorization decisions. This system must be designed to detect both under-and-over utilization of services.
 - Plans must develop, implement and maintain an adequate system for tracking all referrals and follow-up care.

Scope of Services and Clinical Policies

The contractually required scope of services includes all medically necessary covered services, as set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301 and Title 17, CCR, Division 1, Chapter 4, subchapter 13, beginning with section 6840.

MMCD has further defined the scope of services requirements through a series of clinical policy letters specifically intended to assure adequacy of clinical service delivery. These include policies defining:

- Child preventive services
- Childhood lead screening
- Health education
- Health Education Behavioral Assessment
- Contraceptives
- Prenatal care
- Tuberculosis treatment, including Direct Observed Therapy
- Sexually Transmitted Diseases Care

- Major Organ Transplants
- Family Planning Services
- HIV Testing and Counseling
- Immunizations
- Cultural and Linguistic Services
- Hospice Care

Care Coordination

Plans are contractually required to coordinate with other agencies that provide services to Medi-Cal managed care enrollees, and a number of policy letters specify further the nature of required Plan-agency collaboration. These include:

- Mental Health
- California Children's Services (CCS)
- Child Health and Disability Prevention program
- Developmental Services
- Early Intervention
- Local Education Agency Services

In addition, Plans are required to have MOUs with Local Health Departments, which specify the responsibilities of each party in several service areas, such as family planning, immunizations, TB, STD, HIV testing and counseling, maternal and child health. Policy letters, as listed above, supports many of these MOUs.

Finally, Plans are required to coordinate the delivery of WIC services with the local WIC program and dental health services with dental health providers.

Quality Improvement System (QIS) Standards

Plans must implement an effective QIS in accordance with California Law (Title 28, CCR, Section 1300.70). The plans are expected to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The plans are accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the plan and the provider. That QIS system of accountability includes the following:

- Participation of the governing body of the plan's organization;
- Designation of a Quality Improvement Committee with oversight and performance responsibility; the Committee must be accountable to the governing body and the Medical Director must be actively involved.
- Supervision of activities by the Medical Director;

- Inclusion of contracted physicians and other providers in the QIS, including the Quality Improvement Committee.
- Approval by the governing body of a written document including goals and objectives for the delivery of quality health care services.

Additionally, MMCD requires that plans produce an annual quality improvement report. The report will be a comprehensive assessment of the plan's quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program. The report will include, but is not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of quality measures; and outcomes/findings from Quality Improvement Projects (QIPs) and collaborative quality initiatives; and consumer satisfaction surveys."

Appendix D
MMCD Boilerplate Contract Language
(Relevant Sections Only)

Appendix E
MMCD Monitoring Activities
(Selected Examples)

Appendix F
External Accountability Measures

External Accountability Set for Medi-Cal Managed Care Plans

HEDIS Measures

- * Childhood Immunizations
- * Adequate Postpartum Care
- * Adequacy of Prenatal Care
- * Well-Child Visit Rates
- * Well Adolescent Visit Rates
- * Appropriate Use of Asthma Medicines
- * Chlamydia Screening for Young Women
- * Breast Cancer Screening (new in 2004)
- * Cervical Cancer Screening (new in 2004))
- * Eye Exams for People with Diabetes (COHS only)

DHS-Developed Measures

- * Overuse of Asthma Rescue Medicines
- * Childhood Blood Lead Screening

CAHPS Measures

- * Getting needed care
- * Getting care without long waits
- * How well doctors communicate
- * Courtesy and helpfulness of office staff
- * Health plan customer service

